

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08381

CERTIFICATE OF DEATH

0838274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 yes. 8 mos. 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27 0357.2			
4. DATE OF DEATH Month August Day 19, Year 19 57				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Evelyn Margaret Middle Summers Last BARNHART				4. DATE OF DEATH Month August Day 19, Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1908	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 49 Days 19 Hours 57	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Summers				14. MOTHER'S MAIDEN NAME Ellen O'Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the cervix with metastasis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, depressed type							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 16, 1952 , to August 19, 1957 , that I last saw the deceased alive on August 18, 1957 , and that death occurred at 3:15 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 8/19/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8-21-57		Meadowridge Mem Park		Elkridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tracy General Home - Catonsville, Md.				24a. REC'D BY REGISTRAR Aug 21 1957		24b. REGISTRAR'S SIGNATURE C. Harry Kepp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 21 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this form, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08382

CERTIFICATE OF DEATH

Reg. Dist. No.

08383

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>G</u> Last <u>BUSH</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30 - 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jas. Beaumont</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Mrs. Lyman Ehrhart - Westminster</u>		Address <u>Westminster, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>48</u> , to <u>Aug 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>8/31/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>		ADDRESS (Street, city or town, state) <u>Hampstead Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-2-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Chipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>9/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>Henry J. Bell</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08383

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08384

Reg. Dist. No.

Items 3, 13, & 14 - G219 8/9/57 GFB

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 mos. 19 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. STREET ADDRESS 3008 Northway Drive				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Anthony Middle Nicklas Last CARELOS (<i>Carelas</i>)				4. DATE OF DEATH Month August Day 5 Year 19 57				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1897		
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat packer				10b. KIND OF BUSINESS OR INDUSTRY - 4 -				
11. BIRTHPLACE (State or foreign country) Greece				12. CITIZEN OF WHAT COUNTRY? Unknown				
13. FATHER'S NAME Unknown Nicholas Carelas (Carelos)				14. MOTHER'S MAIDEN NAME Unknown Christina				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 4 -				
17. INFORMANT Springfield Hospital Records				Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction Hours 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute coronary occlusion Hours DUE TO (c) Arteriosclerotic heart disease Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 16, 1957 to August 5, 1957 , that I last saw the deceased alive on August 5, 1957 , and that death occurred at 1:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 8/5/57 ACTUAL SIGNATURE Agustin del Campo M.D. Sykesville, Maryland PHYSICIAN'S NAME (Type) Agustin del Campo								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
Burial		8-9-57		Greek Orthodox		Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ronald J. Ruck				ADDRESS 5505 Harford Rd. Balto.				24a. REC'D BY REGISTRAR DATE 8-7-57
				24b. REGISTRAR'S SIGNATURE C. Harry Evers				

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

15526

1. NAME OF DECEASED ALICE OWEN		2. SEX F		3. AGE 60		4. RACE W		5. DATE OF BIRTH JAN 19 1897		6. PLACE OF BIRTH BALTIMORE, MD	
7. DATE OF DEATH AUG 10 1957		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH HOME		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. SIGNATURE OF PHYSICIAN J. H. SMITH	
13. SIGNATURE OF REGISTRAR J. H. SMITH		14. SIGNATURE OF WITNESS J. H. SMITH		15. SIGNATURE OF WITNESS J. H. SMITH		16. SIGNATURE OF WITNESS J. H. SMITH		17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH	

BUREAU V. S.

AUG 9 1957

RECEIVED

08384

CERTIFICATE OF DEATH

08385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 LOCUST AVE.</u>		d. STREET ADDRESS <u>3 LOCUST AVE.</u> 1	
3. NAME OF DECEASED (Type or print) <u>IRIS</u> First <u>TAYLOR</u> Middle <u>CHEW</u> Last		4. DATE OF DEATH <u>AUG.</u> Month <u>24</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 13 1900</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NORRIS TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>FANNY E. EBAUGH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-3791</u>	
17. INFORMANT <u>MRS PAUL PETRY</u> Address <u>3 WILLOW AVE. WESTMINSTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1950</u> to <u>Aug 24 - 1957</u> , that I last saw the deceased alive on <u>Aug 24 - 1957</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm C. J. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md</u> DATE SIGNED <u>Aug 26 - 57</u>	
PHYSICIAN'S NAME (Type) <u>Wm Carl Jennette MD</u>		<u>Westminster Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 27, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FINNRSBURG MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Bankard</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 8-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Muller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARKANSAS STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

JUN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08386

08385

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Feb 3, 1887</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Cope</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. J. O. Cope</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-2055</u>	
17. INFORMANT <u>Mrs. J. O. Cope</u>		Address <u>Woodbine, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reticulum Cell Sarcoma</u> 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>1957</u> , that I last saw the deceased alive on <u>June</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> A.M. from the cause, and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		ADDRESS (Street, city or town, state) <u>Mount Airy, Md.</u> DATE SIGNED <u>Aug 21, 1957</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-24-1957</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Liberty Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Lisbon, Howard Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Maryland</u>	
24a. REC'D BY REGISTRAR <u>2-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u>	

BUREAU V. 5.

JUG 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08386

CERTIFICATE OF DEATH

08387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll Sykesville		c. LENGTH OF STAY IN 1b 18 m-s		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Sykesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Gaither Rd, box 82		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Charles Last COURSEY				4. DATE OF DEATH Month August Day 11 Year 1957			
5. SEX male		6. COLOR OR RACE wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-70	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	
10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME R. Henry COURSEY				14. MOTHER'S MAIDEN NAME Rosanne Lemon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Springfield State Hospital, -Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 491X (b) Bronchopneumonia DUE TO (c) dehydration						INTERVAL BETWEEN ONSET AND DEATH 10 years 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS CONDITION GIVEN IN PART I. with psychotic reaction CBS, associated with disturbance of metabolism, with senile brain disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-24-56 19 to August 1957 that I last saw the deceased alive on August 1957 and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital 8-12-57							
PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-57		22c. NAME OF CEMETERY OR CREMATORY McKendree		22d. LOCATION (City, town, or county) (State) Cooksville, Howard, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Luther B. Knight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 8/12/57	
24b. REGISTRAR'S SIGNATURE C. Henry Tolson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		OCCASION OF DEATH [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF JUDGE [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF [Faint text] [Faint text]	

BUREAU V. 1

AUG 14 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08387

CERTIFICATE OF DEATH

08388 74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Thomas Last Curtis				4. DATE OF DEATH Month 8 Day 31 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 65 ? yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY Home Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Levi Curtis				14. MOTHER'S MAIDEN NAME Annie Bruent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-0938		17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involutionsa psychotic reaction, Diabetes mellitu 260.8							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-6- 19 57 , to 8-31- 19 57 , that I last saw the deceased alive on 8-31- 19 57 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital 8-31-57							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-3-57		22c. NAME OF CEMETERY OR CREMATORY Black Rock Baptist		22d. LOCATION (City, town, or county) (State) Butler, Balto. Co., Mds.	
23. FUNERAL DIRECTOR'S SIGNATURE Leola Brooks-Towson, Md.				24a. REC'D BY REGISTRAR SEP 3 1957		24b. REGISTRAR'S SIGNATURE C. Harry Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH		6. DATE OF BIRTH		7. PLACE OF DEATH		8. CAUSE OF DEATH	
JAMES EARL RAY		Male		35		White		Memphis, Tennessee		April 24, 1928		Memphis, Tennessee		Shot	
9. OCCUPATION		10. MARITAL STATUS		11. EDUCATION		12. RELIGION		13. SERVICE		14. DATE OF DEATH		15. TIME OF DEATH		16. PLACE OF INTERMENT	
None		Single		High School		Methodist		None		April 4, 1968		4:00 PM		Folsom Prison, Folsom, California	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER		21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF CLERK		23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE	

BUREAU V. 5

SEP 3 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08388

08388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hydesville</u>		c. LENGTH OF STAY IN 1b <u>2 years 8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3. NAME OF DECEASED (Type or print) <u>Jane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield</u>		d. STREET ADDRESS <u>409 W 24th Str.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-26-92</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Russell Bell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral circulatory accident</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterioscler. cardiovascular disease years</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Morah</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MAYSK</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Bluck</u>		ADDRESS <u>4210 Belair Rd. Balto. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>8-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

1957
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is mostly blank with some faint markings.

BUREAU V. S.

JUG 6 1957

RECEIVED

08389

CERTIFICATE OF DEATH

Reg. Dist. No.

08390

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20yrs. 3mos. 4days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Hovey Last EDMUNDS				4. DATE OF DEATH Month August Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1870	
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months 8 Days 7 Hours 15 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming-House Keeper & Mechanic		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -				17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid reaction, paranoia. -Arterial embolism and thrombosis of the extremities.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 7, 1955 , to August 3, 1957 , that I last saw the deceased alive on August 3, 1957 , and that death occurred at 10:10 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 8/4/57			
ACTUAL SIGNATURE Agustin del Campo				M.D. Sykesville, Maryland			
PHYSICIAN'S NAME (Type) Agustin del Campo				M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/7/57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Balto. City	
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell				24a. REC'D BY REGISTRAR Aug 8 1957			
24b. REGISTRAR'S SIGNATURE C. Harry Keen				24c. DATE Aug 8 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

AUG 8 1957

RECEIVED

[Handwritten signature and notes at the bottom of the form]

08390

CERTIFICATE OF DEATH

08391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos. 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3153 Lyndale Avenue	
3. NAME OF DECEASED (Type or print) First Catherine Middle Smith Last Donnet FEIGE		4. DATE OF DEATH Month August Day 26, Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1867
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Donnet		14. MOTHER'S MAIDEN NAME Catherine Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 1957 to August 26, 1957 , that I last saw the deceased alive on August 25, 1957 , and that death occurred at 3:34 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		DATE SIGNED 8/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 28/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn Balto md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons		24a. REC'D BY REGISTRAR 8/27/57	
ADDRESS 4905 York Rd		24b. REGISTRAR'S SIGNATURE C. Henry Heers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 ~~will~~ be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES O'NEAL		SEX Male		AGE 35		DATE OF BIRTH 1922	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married	
DATE OF DEATH August 28, 1957		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
DATE OF SIGNATURE (None)		DATE OF SIGNATURE (None)		DATE OF SIGNATURE (None)		DATE OF SIGNATURE (None)	

BUREAU V. 1

AUG 28 1957

RECEIVED

08391

CERTIFICATE OF DEATH

08392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 48yrs.7mos.17days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 404 Greenlawn Drive.	
3. NAME OF DECEASED (Type or print) First Sol Middle FRIEDKIN Last FRIEDKIN		4. DATE OF DEATH Month August Day 9 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Frank Friedkin		14. MOTHER'S MAIDEN NAME Mary Hendin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Minutes Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 , to August 9, 1957 , that I last saw the deceased alive on August 9, 1957 , and that death occurred at 8:30A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 8/9/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Lisensohn + Bro		ADDRESS 1124 W. N. Ave	
24a. REC'D BY REGISTRAR AUG 12 1957		24b. REGISTRAR'S SIGNATURE C. Harry Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES M. JONES		45		M		W		1912		BALTIMORE		BALTIMORE		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		1935		BALTIMORE		BALTIMORE		U.S.A.		1935		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		CITY		COUNTRY		DATE OF GRADUATION		PLACE OF GRADUATION		CITY OF GRADUATION		COUNTRY OF GRADUATION	
HIGH SCHOOL		BALTIMORE		BALTIMORE		U.S.A.		1930		BALTIMORE		BALTIMORE		U.S.A.	
OCCUPATION		BUSINESS		CITY		COUNTRY		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		COUNTRY OF OCCUPATION	
BUSINESS		BALTIMORE		BALTIMORE		U.S.A.		1935		BALTIMORE		BALTIMORE		U.S.A.	
CAUSE OF DEATH		HEART DISEASE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
HEART DISEASE		BALTIMORE		BALTIMORE		U.S.A.		1957		BALTIMORE		BALTIMORE		U.S.A.	
MANNER OF DEATH		NATURAL		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
NATURAL		BALTIMORE		BALTIMORE		U.S.A.		1957		BALTIMORE		BALTIMORE		U.S.A.	
SIGNATURE OF PHYSICIAN		JAMES M. JONES		CITY		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE	
JAMES M. JONES		BALTIMORE		BALTIMORE		U.S.A.		1957		BALTIMORE		BALTIMORE		U.S.A.	
SIGNATURE OF REGISTRAR		JAMES M. JONES		CITY		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE	
JAMES M. JONES		BALTIMORE		BALTIMORE		U.S.A.		1957		BALTIMORE		BALTIMORE		U.S.A.	

BUREAU V. S.

AUG 12 1957

RECEIVED

08392

CERTIFICATE OF DEATH

08392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Woodbine	
3. NAME OF DECEASED (Type or print) First ANNE Middle CATHERINE Last GOSNELL		4. DATE OF DEATH Month August Day 2 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1878
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 9 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Gosnell		14. MOTHER'S MAIDEN NAME Anne ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Donald Gosnell		Address Balto 3127 Ravenwood Ave., 13	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Cardiac arrest, Carcinoma of DUE TO (b) Chronic generalized mitral stenosis, anemia, DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1956 to Aug 57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10 May, 1957 to 2 August, 1957 , that I last saw the deceased alive on 2 August, 1957 , and that death occurred at 8: P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 2 Aug. 57	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-5-1957	22c. NAME OF CEMETERY Morgan Chapel	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR AUG 6 1957		24b. REGISTRAR'S SIGNATURE Harry Keys	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08393

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 228 - 10th Street, N.E.	
3. NAME OF DECEASED (Type or print) First David Middle McKinley Last Gray, Jr.		4. DATE OF DEATH Month August Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1925
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) High Point, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Gray, Sr.		14. MOTHER'S MAIDEN NAME Victoria Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. II 244-30-8905	
17. INFORMANT David McKinley Gray, Jr. - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, lung 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced cavitory pulmonary tuberculosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-17- 1956 , to 8-7- 1957 , that I last saw the deceased alive on 8-7- 1957 , and that death occurred at 10:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. M. Maculans		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 8-7-57	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D.		Henryton State Hospital, Henryton, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-13-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat.	22d. LOCATION (City, town, or county) (State) Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE R. D. Horton		24a. REC'D BY REGISTRAR 1322 York St. Wash. D.C.	
24b. REGISTRAR'S SIGNATURE Albert R. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. BOWEN		DATE OF BIRTH JAN 15 1905		PLACE OF BIRTH BALTIMORE, MD	
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 15 1935		PLACE OF MARRIAGE BALTIMORE, MD	
OCCUPATION LABORER		DATE OF DEATH AUG 12 1957		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN J. E. BOWEN		SIGNATURE OF DECEASED JAMES E. BOWEN		SIGNATURE OF WITNESS J. E. BOWEN	
DATE OF SIGNATURE AUG 12 1957		DATE OF SIGNATURE AUG 12 1957		DATE OF SIGNATURE AUG 12 1957	

RECEIVED
AUG 12 1957
BUREAU V. E.

08394

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco				c. LENGTH OF STAY IN 1b 26 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Kate Middle Gray Last Gray				4. DATE OF DEATH Month August Day 10 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1881		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME George Dew				14. MOTHER'S MAIDEN NAME Charlotte (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Norman Barrick Address Patapsco, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Generalized Arteriosclerosis DUE TO (c) Chronic nephritis						INTERVAL BETWEEN ONSET AND DEATH 2 days 15 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/8/57 to 8/10/57 , that I last saw the deceased alive on 8/9/57 , and that death occurred at 12:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Luther Bare				DATE SIGNED 8/10/57			
PHYSICIAN'S NAME (Type) S. Luther Bare				ADDRESS 79 W. Main St. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR 8-13-57	
24b. REGISTRAR'S SIGNATURE Harriet Miller							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08395

CERTIFICATE OF DEATH

08396

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Wilkes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>18 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shand Thor Nursing Home</u>		d. STREET ADDRESS <u>Salisbury 2212.2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hannie S. Higgins</u>		4. DATE OF DEATH Month Day Year <u>August 10 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Cornelius Wright</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ellwood Higgins</u>		Address <u>2905 Harford Rd. Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease with arteriosclerosis and chronic myocarditis</u> DUE TO (b) <u>advanced senile changes</u> DUE TO (c) <u>fracture, simple, through greater trochanter of left hip femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9037</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u> <u>1 1/2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>slipped on bathroom floor and fell, fracturing left femur</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6</u> <u>25</u> , <u>1957</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>nursing home</u>	20f. (City or town) (County) (State) <u>Sykesville Carroll Md.</u>
21. I certify that I attended the deceased from <u>1 January</u> , 19 <u>55</u> , to <u>10 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 August</u> , 19 <u>57</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>8/10/57</u>			
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u>		M.D. <u>Liberty Road at Eldersburg</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverton</u>	22d. LOCATION (City, town, or county) (State) <u>Maidella, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway Co.</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>8-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harrison</u>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL PLACE	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF CLERK		21. SIGNATURE OF CHIEF CLERK	
22. SIGNATURE OF DEPUTY CLERK		23. SIGNATURE OF ASSISTANT CLERK		24. SIGNATURE OF RECORDS CLERK	
25. SIGNATURE OF VITALS CLERK		26. SIGNATURE OF VITALS CLERK		27. SIGNATURE OF VITALS CLERK	
28. SIGNATURE OF VITALS CLERK		29. SIGNATURE OF VITALS CLERK		30. SIGNATURE OF VITALS CLERK	
31. SIGNATURE OF VITALS CLERK		32. SIGNATURE OF VITALS CLERK		33. SIGNATURE OF VITALS CLERK	
34. SIGNATURE OF VITALS CLERK		35. SIGNATURE OF VITALS CLERK		36. SIGNATURE OF VITALS CLERK	
37. SIGNATURE OF VITALS CLERK		38. SIGNATURE OF VITALS CLERK		39. SIGNATURE OF VITALS CLERK	
40. SIGNATURE OF VITALS CLERK		41. SIGNATURE OF VITALS CLERK		42. SIGNATURE OF VITALS CLERK	
43. SIGNATURE OF VITALS CLERK		44. SIGNATURE OF VITALS CLERK		45. SIGNATURE OF VITALS CLERK	
46. SIGNATURE OF VITALS CLERK		47. SIGNATURE OF VITALS CLERK		48. SIGNATURE OF VITALS CLERK	
49. SIGNATURE OF VITALS CLERK		50. SIGNATURE OF VITALS CLERK		51. SIGNATURE OF VITALS CLERK	
52. SIGNATURE OF VITALS CLERK		53. SIGNATURE OF VITALS CLERK		54. SIGNATURE OF VITALS CLERK	
55. SIGNATURE OF VITALS CLERK		56. SIGNATURE OF VITALS CLERK		57. SIGNATURE OF VITALS CLERK	
58. SIGNATURE OF VITALS CLERK		59. SIGNATURE OF VITALS CLERK		60. SIGNATURE OF VITALS CLERK	
61. SIGNATURE OF VITALS CLERK		62. SIGNATURE OF VITALS CLERK		63. SIGNATURE OF VITALS CLERK	
64. SIGNATURE OF VITALS CLERK		65. SIGNATURE OF VITALS CLERK		66. SIGNATURE OF VITALS CLERK	
67. SIGNATURE OF VITALS CLERK		68. SIGNATURE OF VITALS CLERK		69. SIGNATURE OF VITALS CLERK	
70. SIGNATURE OF VITALS CLERK		71. SIGNATURE OF VITALS CLERK		72. SIGNATURE OF VITALS CLERK	
73. SIGNATURE OF VITALS CLERK		74. SIGNATURE OF VITALS CLERK		75. SIGNATURE OF VITALS CLERK	
76. SIGNATURE OF VITALS CLERK		77. SIGNATURE OF VITALS CLERK		78. SIGNATURE OF VITALS CLERK	
79. SIGNATURE OF VITALS CLERK		80. SIGNATURE OF VITALS CLERK		81. SIGNATURE OF VITALS CLERK	
82. SIGNATURE OF VITALS CLERK		83. SIGNATURE OF VITALS CLERK		84. SIGNATURE OF VITALS CLERK	
85. SIGNATURE OF VITALS CLERK		86. SIGNATURE OF VITALS CLERK		87. SIGNATURE OF VITALS CLERK	
88. SIGNATURE OF VITALS CLERK		89. SIGNATURE OF VITALS CLERK		90. SIGNATURE OF VITALS CLERK	
91. SIGNATURE OF VITALS CLERK		92. SIGNATURE OF VITALS CLERK		93. SIGNATURE OF VITALS CLERK	
94. SIGNATURE OF VITALS CLERK		95. SIGNATURE OF VITALS CLERK		96. SIGNATURE OF VITALS CLERK	
97. SIGNATURE OF VITALS CLERK		98. SIGNATURE OF VITALS CLERK		99. SIGNATURE OF VITALS CLERK	
100. SIGNATURE OF VITALS CLERK		101. SIGNATURE OF VITALS CLERK		102. SIGNATURE OF VITALS CLERK	

BUREAU V. S.

AUG 12 1957

RECEIVED

08396

CERTIFICATE OF DEATH

08398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4yr. 8mo. 29da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 105 W. 4th Street			
3. NAME OF DECEASED (Type or print) First William Middle Baker Last JAMES				4. DATE OF DEATH Month August Day 4 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-72	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Contractor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joshua James				
14. MOTHER'S MAIDEN NAME Mary Baker			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Address Springfield State Hospital - Sykesville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old Rheumatic heart disease plus Bronchopneumonia 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 1191X (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, circulatory disturbance, cerebral arterio-sclerosis, with psychotic reaction. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from November 5, 1952 , to August 4, 1957 , that I last saw the deceased alive on August 4, 1957 , and that death occurred at 4:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital 8-5-57 PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 8/6/57		22c. NAME OF CEMETERY OR CREMATORY Int. Clint		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE H. E. Cantyler				ADDRESS Frederick, Md		24a. REC'D BY REGISTRAR DATE _____	
24b. REGISTRAR'S SIGNATURE Harry Key							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08397

CERTIFICATE OF DEATH

08399

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2/17/55	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown 10 x 12		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Manzella Yingling Kanode		4. DATE OF DEATH Month Day Year 8 9 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/78
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edmond Yingling		14. MOTHER'S MAIDEN NAME Sara Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT David E. Kanode, Adamstown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart disease 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CBS assoc. with circulatory disturbance, with (c) cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/17 , 19 55 , to 8/9 , 19 57 , that I last saw the deceased alive on 8/8 , 19 57 , and that death occurred at 5 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrud Sommerfeldt H.D. Springfield State Hospital Sykesville Md.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Gertrud Sommerfeldt H.D. Springfield State Hospital Sykesville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-12-57	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 8-12-57	
24b. REGISTRAR'S SIGNATURE C. Harry Wood			

BUREAU V. S.

AUG 14 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b 2mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Taneytown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) RALPH C. LOOKINGBILL			4. DATE OF DEATH Month AUG. Day 6, Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1942		9. AGE (In years last birthday) 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) in school		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Aubrey Lookingbill			14. MOTHER'S MAIDEN NAME Ethel M. Watson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Aubrey Lookingbill, R.D. Mt. Airy, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUFFOCATION - by HANGING 974x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging by the neck			
20c. TIME OF INJURY Month, Day, Year Aug 6 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Taneytown	(County) Carroll	(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James J. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/6/57	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-9-1957	22c. NAME OF CEMETERY Taylorville	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,			24a. REC'D BY REGISTRAR AUG 9 '57		
ADDRESS Winfield, Maryland			24b. REGISTRAR'S SIGNATURE DeLoach		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 9 1957

BUREAU V. S.

08399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 1 yr 1mo. 26 days		d. STREET ADDRESS 420 S. Lehigh St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle L. Last MARKEL SR.		4. DATE OF DEATH Month August Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1877
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Markel		14. MOTHER'S MAIDEN NAME Mary E. Hornstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium due to arteriosclerotic coronary thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Instant Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital
20f. (City or town) Sykesville		(County) (State)
21. I certify that I attended the deceased from June 23, 1956 , to August 19, 1957 , that I last saw the deceased alive on August 19, 1957 , and that death occurred at 9:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 8/19/57		
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-22-57	22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.
22d. LOCATION (City, town, or county) 7225 EASTERN BLVD., MD.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Seiler		24a. REC'D BY REGISTRAR Aug 22 1957
ADDRESS 9015 CONKLING ST. BALTO., MD.		REGISTRAR'S SIGNATURE C. Harry Kemp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08400

CERTIFICATE OF DEATH

08402

Reg. Dist. No. 174

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>1 mo 29 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>				e. STREET ADDRESS <i>3222 Ravenwood Ave.</i>			
3. NAME OF DECEASED (Type or print) <i>Virgil</i> First Middle Last <i>Markey</i>				4. DATE OF DEATH <i>Aug - 18</i> Month Day Year <i>1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-11-1883</i>	
9. AGE (In years, last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer & odd jobs</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frank Markey</i>				14. MOTHER'S MAIDEN NAME <i>Cornelia Cofield</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>179-20-9202</i>		17. INFORMANT <i>hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rheumatic valvulitis (mitralis) inactive with deformity of valve</i> <i>414X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.B.S. ass. with senile dementia with psychotic reactions</i>						INTERVAL BETWEEN ONSET AND DEATH <i>years.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>June - 20, 1957</i> to <i>August - 18, 1957</i> , that I last saw the deceased alive on <i>August - 17, 1957</i> , and that death occurred at <i>9:40 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.				ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> DATE SIGNED <i>8/18/57</i>			
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>				<i>Sykesville Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 21, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sunnyside Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>York Spring Adams Co PA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. L. Veltrop</i> ADDRESS <i>York Spring Pa</i>				24a. REC'D BY REGISTRAR <i>C. Harry Weller</i>		24b. REGISTRAR'S SIGNATURE	

AUG 21 1957

RECEIVED

08401

CERTIFICATE OF DEATH

08403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle Mae Last MEYERS				4. DATE OF DEATH Month August Day 16 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John - LONG				14. MOTHER'S MAIDEN NAME Nancy Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 29, 1957 to August 16, 1957 , that I last saw the deceased alive on August 15, 1957 , and that death occurred at 4:35A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 8/16/57							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		aug 19/57		Manchester		Carroll Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin C. Tipton				ADDRESS Hampstead, Md.		24a. REC'D BY REGISTRAR DATE 8-18-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Allen			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Aug 21 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

8379

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE MD. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. LENGTH OF STAY IN 1b 75 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 4				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle OWINGS Last REBERT				4. DATE OF DEATH Month AUG. Day 24 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 7, 1882 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 75 yrs.	
11. BIRTHPLACE (State or foreign country) MD.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME DAVIDA. OWINGS				14. MOTHER'S MAIDEN NAME MART E. SHUEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT CLAUDE V. REBERT Address R.D. 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (Genl) DUE TO (c) Brachiectasis						INTERVAL BETWEEN ONSET AND DEATH 5da 5yrs. 20yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 20 , 19 57 , to Aug 24 , 19 57 , that I last saw the deceased alive on Aug 24 , 19 57 , and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Speicher				ADDRESS (Street, city or town, state) Westminster Md			
PHYSICIAN'S NAME (Type) William Speicher				DATE SIGNED 8/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY LEISTER CEMETERY		22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David G. Bankard				ADDRESS Westminster Md		24a. REC'D BY REGISTRAR DATE 8-28-57	
				24b. REGISTRAR'S SIGNATURE Harriet Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
SEP 3 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08402

CERTIFICATE OF DEATH

08405

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 2,468 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01.4			
d. STREET ADDRESS 634 Cheraton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Helen Louise Richardson				4. DATE OF DEATH Month Day Year 8 5 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-1917	
9. AGE (In years last birthday) 40 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Maid		10b. KIND OF BUSINESS OR INDUSTRY Hutzler Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A?		13. FATHER'S NAME Harrison Evans		14. MOTHER'S MAIDEN NAME Clara Copper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-28-1418		17. INFORMANT Helen Louise Richardson - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic rheumatic heart disease DUE TO (c) Far advanced bilateral pulmonary TB, right							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Henryton, Maryland				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11-2- , 19 50 , to 8-5-57 , 19____, that I last saw the deceased alive on 8-5- , 19 57 , and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T.F. Vestal				M.D. Henryton, Maryland		DATE SIGNED 8-5-57	
PHYSICIAN'S NAME (Type) T. F. Vestal, M.D., Supt.				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/57		22c. NAME OF CEMETERY OR CREMATORY Isidore Mem. Cem.		22d. LOCATION (City, town, or county) (State) Haithtown Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Metropolitan Funeral Home Inc.				ADDRESS 1504 Laureate St		24a. REC'D BY REGISTRAR DATE 8-6-57	
				24b. REGISTRAR'S SIGNATURE Albert R. Frankham			

BUREAU V. 5

AUG 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08473

0840687483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Woodbine		c. LENGTH OF STAY in 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Woodbine XI		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pickett's Corner							
3. NAME OF DECEASED (Type or print) First CHARLES Middle W Last RIDGELEY, JR				4. DATE OF DEATH Month 8 Day 24 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1928	
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min. 29		IF UNDER 24 HRS. Months 29 Days 29 Hours 29 Min. 29			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles W. Ridgeley, Sr.				14. MOTHER'S MAIDEN NAME Charlotte Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. Dec. 1956		16. SOCIAL SECURITY NO. See above 1956		17. INFORMANT Address Char. W. Ridgeley - Woodbine Rd. 1 Ynd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HANGING 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour 19 a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				DATE SIGNED 8-25-57			
EXAMINER'S NAME (Type) PAUL F. GUERIN				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-57		22c. NAME OF CEMETERY OR CREMATORY MT. View		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur W. Haight				ADDRESS Hyphumville, Md		24a. REC'D BY REGISTRAR 8-26-57	
				24b. REGISTRAR'S SIGNATURE Robert Thwaitz			

RECEIVED

AUG 28 1957

BUREAU V. S.

WIND BOUND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08404

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11mos.3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 721 Dale Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Nella Ann Shackleton ROBINSON				4. DATE OF DEATH Month Day Year August 13, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ben Shackleton				14. MOTHER'S MAIDEN NAME Anna Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-03-3336-A		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. Ischiorectal abscess.							INTERVAL BETWEEN ONSET AND DEATH Days Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from Sept. 10, 1956 , to August 13, 1957 , that I last saw the deceased alive on August 13, 1957 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walther H. Sonnenfeldt, M.D. Springfield State Hospital 8/13/57							
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland					
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF 8/15/57	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Tunney		ADDRESS Silver Spring 8434 E. Ave. - Mt.		24a. REC'D BY REGISTRAR DATE 8-18-57	24b. REGISTRAR'S SIGNATURE C. Harry Allen		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH—BANK ONE 18

Form 100-100

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH CERTIFICATE OFFICER	
NAME OF DECEASED		NAME OF DECEASED	
AGE		AGE	
SEX		SEX	
RACE		RACE	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF DEATH CERTIFICATE OFFICER	
DATE OF REGISTRATION		DATE OF REGISTRATION	
OFFICE OF REGISTRATION		OFFICE OF REGISTRATION	
FEE		FEE	
REMARKS		REMARKS	

BUREAU V. S.

AUG 21 1957

RECEIVED

08405

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08408

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 7, 13, 14, G202 9/23/57

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, WESTMINSTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HELEN THERESA ROSEVEAR		4. DATE OF DEATH Month Day Year AUG. 30 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY DRUG STORE	
11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERBERT ROSEVEAR		14. MOTHER'S MAIDEN NAME NELLIE FELTIS Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-80-0236	
17. INFORMANT MRS. MAURICE C. PEREGGY		Address WESTMINSTER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laryngitis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer breast DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Leucemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1956 , to Aug. 30, 1957 , that I last saw the deceased alive on Aug. 29, 1957 , and that death occurred at 7:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 E. Main Westminster, Md. DATE SIGNED 8/30/57			
ACTUAL SIGNATURE James J. Marsh M.D.		PHYSICIAN'S NAME (Type) JAMES T. MARSH	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 2 '57	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEMORIAL	22d. LOCATION (City, town, or county) (State) FINKSBURG, MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr. Westminster, Md.		24a. REC'D BY REGISTRAR DATE 8-31-57	24b. REGISTRAR'S SIGNATURE Harriet Miller

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

REG. CHG. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF MINISTER		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF CLERK		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF TOWNSHIP CLERK		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF STATE CLERK		24. SIGNATURE OF NATIONAL CLERK	

25. NAME OF DECEASED		26. SEX		27. AGE		28. RACE		29. DATE OF BIRTH		30. PLACE OF BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH		34. CAUSE OF DEATH		35. MANNER OF DEATH		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF MINISTER		40. SIGNATURE OF CORONER		41. SIGNATURE OF JURY		42. SIGNATURE OF JUDGE	
43. SIGNATURE OF CLERK		44. SIGNATURE OF SHERIFF		45. SIGNATURE OF TOWNSHIP CLERK		46. SIGNATURE OF COUNTY CLERK		47. SIGNATURE OF STATE CLERK		48. SIGNATURE OF NATIONAL CLERK	

49. NAME OF DECEASED		50. SEX		51. AGE		52. RACE		53. DATE OF BIRTH		54. PLACE OF BIRTH	
55. DATE OF DEATH		56. TIME OF DEATH		57. PLACE OF DEATH		58. CAUSE OF DEATH		59. MANNER OF DEATH		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF PHYSICIAN		63. SIGNATURE OF MINISTER		64. SIGNATURE OF CORONER		65. SIGNATURE OF JURY		66. SIGNATURE OF JUDGE	
67. SIGNATURE OF CLERK		68. SIGNATURE OF SHERIFF		69. SIGNATURE OF TOWNSHIP CLERK		70. SIGNATURE OF COUNTY CLERK		71. SIGNATURE OF STATE CLERK		72. SIGNATURE OF NATIONAL CLERK	

RECEIVED
SEP 3 1957
BUREAU V. S.

08406

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 y 1 m 17 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1726 N. Collington Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mamie Middle Angela Last Haug SCHMIDT				4. DATE OF DEATH Month August Day 10 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1870	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Haug				14. MOTHER'S MAIDEN NAME Mary Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 24, 1955 , to August 10, 1957 , that I last saw the deceased alive on August 10, 1957 , and that death occurred at 9:35 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 8-11-57			
ACTUAL SIGNATURE Edmund Lusthaus M.D.							
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/14/1957		Baltimore Cemetery		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ronald J. Ruck				ADDRESS 5305 Airford Rd. Balt.		24a. REC'D BY REGISTRAR DATE 8-11-57	
				24b. REGISTRAR'S SIGNATURE C. Henry W. W.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 10 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08410

08407

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1957</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 20, 1887</u> 9. AGE (in years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>15</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Matthew Murray</u>				14. MOTHER'S MAIDEN NAME <u>Susan Molesworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>John D. Smith</u> Address <u>Mt. Airy Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO (b) <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>more than 6 months.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 7</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.				ADDRESS (Street, city or town, state) <u>Mount Airy</u> DATE SIGNED <u>Aug 9, 1957</u>			
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Howard Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Long Corner, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Molesworth</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR <u>8-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u>	

08408

CERTIFICATE OF DEATH

08411

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5509 Richard Avenue			
3. NAME OF DECEASED (Type or print) First Bertha Middle Elizabeth Last Stonesifer				4. DATE OF DEATH Month August Day 22 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1889		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Stonesifer				14. MOTHER'S MAIDEN NAME Mary C. Bricker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-4775		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrospinal arteriosclerosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic brain syndrome associated with convulsive disorder with psychotic reaction DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 8, 1957 , to August 22, 1957 , that I last saw the deceased alive on August 22, 1957 , and that death occurred at 10:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 8/23/57	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				SYLVESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/57		22c. NAME OF CEMETERY OR CREMATORY Western Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto.				24. REC'D BY REGISTRAR AUG 27 1957 24b. REGISTRAR'S SIGNATURE C. Harry Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

Place of Death

Maryland

County

City or Town of Residence

Residence

Age

Sex

Occupation

Date of Death

Time

Day

Month

Year

A record of this death is being made in the following manner:

1. In the death certificate of the deceased.

2. In the death certificate of the informant.

3. In the death certificate of the physician.

4. In the death certificate of the coroner.

5. In the death certificate of the registrar.

6. In the death certificate of the funeral director.

7. In the death certificate of the cemetery.

8. In the death certificate of the burial.

9. In the death certificate of the interment.

10. In the death certificate of the cremation.

11. In the death certificate of the disposition.

12. In the death certificate of the final disposition.

13. In the death certificate of the final disposition.

14. In the death certificate of the final disposition.

15. In the death certificate of the final disposition.

16. In the death certificate of the final disposition.

17. In the death certificate of the final disposition.

18. In the death certificate of the final disposition.

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32. In the death certificate of the final disposition.

33. In the death certificate of the final disposition.

34. In the death certificate of the final disposition.

35. In the death certificate of the final disposition.

BUREAU V. S.

JUN 28 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film G219, 8/25/57 icy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedarhurst		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Cedarhurst	
		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle G. Last TRUMP SR.		4. DATE OF DEATH Month August Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1886
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Wesley Trump		14. MOTHER'S MAIDEN NAME Annie Houck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO. 216-07-4211	
17. INFORMANT Mrs. Annie Teump, Cedarhurst, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Neck 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs.	
20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 8/19 57		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home partial	
20e. (City or town) Cedarhurst		20f. (County) Carroll (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		DATE SIGNED 8/19/57	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August, 22 57	
22c. NAME OF CEMETERY OR CREMATORY Finksburg Cem.		22d. LOCATION (City, town, or county) (State) Finksburg, Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24. REC'D BY REGISTRAR 8-20-57	
		24b. REGISTRAR'S SIGNATURE Harriet Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

OCCUPATION

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

INITIALS

DATE OF BIRTH

DATE OF DEATH

DATE OF EXAMINATION

DATE OF DEATH

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

U.S.A.

BUREAU V. S.

AUG 21 1957

RECEIVED

Paul F. Jones

Paul F. Jones

Paul F. Jones

Paul F. Jones

08410

CERTIFICATE OF DEATH

08413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 16 Carroll Street	
3. NAME OF DECEASED (Type or print) First Mamie Middle Frances Derr Last Wampler		4. DATE OF DEATH Month 8 Day 24 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Derr		14. MOTHER'S MAIDEN NAME Mary Metzger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to Decubitus Ulcers 0533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebr. arterioscler. with psych. react. Parkinson disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-5- 19 57 , to 8-24- 19 57 , that I last saw the deceased alive on August 24, 19 57 , and that death occurred at 9:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital 8-25-57			
ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 8-25-57			
PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 27-57	Kriders Cemetery	Rural, Westminster, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.		ADDRESS Westminster, Md.	24a. REG'D BY REGISTRAR Aug 31-57
		24b. REGISTRAR'S SIGNATURE C. H. Myers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 3

SEP 4 1957

RECEIVED

08411

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 7</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MILTON</u> First <u>C.</u> Middle <u>WANTZ</u> Last				4. DATE OF DEATH <u>AUG.</u> Month <u>7</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 6, 1880</u> 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		9. AGE (In years lost birthday) <u>76</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WANTZ</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>ANNIE YOUNG</u>			
16. SOCIAL SECURITY NO. <u>NO ONE</u>				17. INFORMANT <u>ALFRED YOUNG WESTMINSTER, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>years -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1950</u> to <u>Aug 6</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Aug 6</u> , 19 <u>57</u> , and that death occurred at <u>135 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James I. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>8/6/57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-9-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MAIDERS CEMETARY WESTMINSTER, MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 8-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08412

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08415

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Liberty Dam		d. STREET ADDRESS 3814 Sylvan Drive #7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOROTHY Middle R. Last WARFIELD		4. DATE OF DEATH Month August Day 13, Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1917
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Hildebrandt		14. MOTHER'S MAIDEN NAME Kemp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mr. Edward G. Warfield-3814 Sylvan Drive - #7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 975x DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned self	
20c. TIME OF INJURY Month, Day, Year 5/13/57 Hour a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Liberty Dam		20f. (City or town) (County) (State) Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 8/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/57	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor		ADDRESS Wm. J. Tichenor & Pa. Ave.	
24a. REC'D BY REGISTRAR Dr. J. M. Hester		24b. REGISTRAR'S SIGNATURE Dr. J. M. Hester	

MEDICAL CERTIFICATION

RECEIVED
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08413

CERTIFICATE OF DEATH

08416

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 9yrs.2mos.15days d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster 27 d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle WELLS Last WELLS				4. DATE OF DEATH Month August Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1877	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 79		IF UNDER 24 HRS. Days 79 Hours 79 Min. 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward D. Wells, M.D.		14. MOTHER'S MAIDEN NAME Mary Josephine Mathias	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 151X DUE TO (c) 151X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency, Imbecile Level.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 1950 to August 25, 1957 that I last saw the deceased alive on August 25, 1957 and that death occurred at 5:30P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 8/26/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-28-57		22c. NAME OF CEMETERY OR CREMATORY St. John's Catholic		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.				24a. REC'D BY REGISTRAR DATE 8-26-57		24b. REGISTRAR'S SIGNATURE C. Harry Allen	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1880-01-15	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TIME OF DEATH	
1927-08-10		Baltimore, Md.		10:00 AM		10:00 AM	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF MINISTER	
Dr. J. H. Harris		Harris Funeral Home		Greenwood Cemetery		Rev. J. H. Harris	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF MINISTER	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1927-08-10		1927-08-10		1927-08-10		1927-08-10	

BUREAU V. S.

AUG 28 1927

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Wildasin

08414

CERTIFICATE OF DEATH

08417

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Nr. Westminster</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Nr. Westminster</u> X1				d. STREET ADDRESS <u>Myers District</u> <u>Westminster, Md. R.D.1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Myers District) Westminster, Md. R.D.1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Catherine</u> Last <u>Wildasin</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1880</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Her own home</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Josiah Wantz</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Roser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Irene Kump</u> Address <u>Mrs. Irene Kump, Westminster, Md. R. D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senile Degeneration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Degeneration</u> INTERVAL BETWEEN ONSET AND DEATH <u>34 years</u> <u>10 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 12, 1956</u> to <u>Aug. 21, 1957</u> , that I last saw the deceased alive on <u>Aug. 6, 1957</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. S. McVaugh</u> M.D. <u>49 Frederick St.</u>				DATE SIGNED <u>8/21/57</u>			
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>				<u>Taneytown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Piney Creek Brethern Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Taneytown, Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>				ADDRESS <u>Littlestown, Pa.</u>		24a. REC'D BY REGISTRAR <u>8-22-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

08415

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Sykesville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS / Rural--Sykesville			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SAMUEL Middle WILSON Last WILSON				4. DATE OF DEATH Month Aug. Day 29 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1869		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicholas Wilson				14. MOTHER'S MAIDEN NAME Mary Jane Wheeler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Oscar Wilson, R.D. Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis (Chr) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis (Chr) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1937 , to Aug 29, 1957 , that I last saw the deceased alive on Aug 28, 1957 , and that death occurred at 4 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Isomith M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 103 E Main Westminster Md 8-30-57			
PHYSICIAN'S NAME (Type) Wm Carl Jannette MD				ADDRESS 103 E Main Westminster Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-31-1957		22c. NAME OF CEMETERY OR CREMATORY Harmony Grove		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR SEP 3 1957	
				24b. REGISTRAR'S SIGNATURE Robert Hewitt			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE ONE 10

NAME OF DECEASED WILLIAM J. WILSON		DATE OF DEATH SEP 2 1957	
AGE 45		SEX MALE	
RACE WHITE		BIRTH DATE 1912	
PLACE OF BIRTH NEW YORK		CITY OF BIRTH NEW YORK	
MARRIAGE MARRIED		SPOUSE'S NAME MARY J. WILSON	
OCCUPATION SALES		EDUCATION HIGH SCHOOL	
RELIGION ROMAN CATHOLIC		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH HOME		CITY OF DEATH BALTIMORE	
DATE OF BURIAL SEP 3 1957		PLACE OF BURIAL CATHOLIC CHURCH	
SIGNATURE OF DECEASED WILLIAM J. WILSON		SIGNATURE OF WITNESS MARY J. WILSON	
SIGNATURE OF PHYSICIAN DR. J. H. WILSON		SIGNATURE OF CORONER JOHN J. WILSON	
SIGNATURE OF REGISTRAR JOHN J. WILSON		SIGNATURE OF CLERK JOHN J. WILSON	

BUREAU V. S.

SEP 3 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08380

08419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>335 E MAIN ST</u>		d. STREET ADDRESS <u>335 E MAIN ST</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>REBECCA</u> Last <u>WOLFE</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20 - 1873</u>
9. AGE (in years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>DANIEL WOLFE</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN HAINES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ANY WOLFE</u>		Address <u>WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 27 - 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartzler & Sons</u>		ADDRESS <u>Union Bridge</u>	
24a. REC'D BY REGISTRAR DATE <u>8-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
HEALTH DEPT.

67280

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

SEP 3 1957

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